

# St. Bartholomew's Hospital



"Æquam memento rebus in arduis  
Servare mentem."  
—Horace, Book ii, Ode iii.

## JOURNAL.

VOL. XLII.—No. 4.]

JANUARY 1ST, 1935.

PRICE NINEPENCE.

### CALENDAR.

- Tues., Jan. 1.—Dr. Graham and Mr. Roberts on duty.  
Fri., „ 4.—Prof. L. J. Witts and Prof. Gask on duty.  
Sat., „ 5.—Rugby Match *v.* Harlequins. Home.  
Association Match *v.* Old Monovians. Home.  
Mon., „ 7.—Special Subjects: Lecture by Dr. Cumberbatch.  
Tues., „ 8.—Lord Horder and Sir Charles Gordon-Watson on duty.  
Wed., „ 9.—Surgery: Clinical Lecture by Mr. Wilson.  
Hockey Match *v.* Guy's Hospital. Home.  
Fri., „ 11.—Dr. Hinds Howell and Mr. Wilson on duty.  
Medicine: Clinical Lecture by Dr. Hinds Howell.  
Sat., „ 12.—Rugby Match *v.* Wasps. Home.  
Hockey Match *v.* Sevenoaks. Away.  
Mon., „ 14.—Special Subjects: Lecture by Mr. Elmslie.  
Tues., „ 15.—Dr. Gow and Mr. Girling Ball on duty.  
**Christmas Entertainment:** "The Nelson Touch" (Jan. 15th to 18th).  
Wed., „ 16.—Surgery: Clinical Lecture by Sir Charles Gordon-Watson.  
Fri., „ 18.—Medicine: Clinical Lecture by Dr. Gow.  
Dr. Graham and Mr. Roberts on duty.  
Sat., „ 19.—Rugby Match *v.* Nuneaton. Away.  
Association Match *v.* Old Bradfieldians. Home.  
Hockey Match *v.* Harlesden. Away.  
**Pot-pourri of Christmas Ward Shows.**  
**Last day for receiving matter for the February issue of the Journal.**  
Mon., „ 21.—Special Subjects: Lecture by Mr. Just.  
Tues., „ 22.—Prof. Witts and Prof. Gask on duty.  
Wed., „ 23.—Surgery: Clinical Lecture by Mr. Wilson.  
Thurs., „ 24.—1st Round Inter-Hospitals Hockey Cup. Bart.'s *v.* Westminster. Away.  
**Abernethian Society: Mid-Sessional Address by Mr. Hugh Cairns on "Recent Advances in Intra-cranial Surgery".**  
Fri., „ 25.—Lord Horder and Sir Charles Gordon-Watson on duty.  
Sat., „ 26.—Rugby Match *v.* Old Alleynians. Home.  
Association Match *v.* Old Aldenhamians. Home.  
Hockey Match *v.* R.N. & R.M. Chatham. Home.  
Mon., „ 28.—Special Subjects: Lecture by Mr. Sidney Scott.  
Tues., „ 29.—Dr. Hinds Howell and Mr. Wilson on duty.  
Wed., „ 30.—Surgery: Clinical Lecture by Mr. Girling Ball.  
Association Match *v.* Balliol College, Oxford. Away.  
Hockey Match *v.* Shoburness Garrison. Away.

### EDITORIAL.

**W**E have been assured by the Press, the politicians, and even by the usually morose Old Moore that the New Year was the corner beyond which prosperity has lurked for so long. The assurance comes with the same optimism that the doctor employs to rouse a despairing patient: "You're getting on finely: we'll have you up in no time." Whether the patient has been duly impressed or not, a new spirit of gaiety and almost extravagant abandon has marked such occasions as the Royal Wedding and the Christmas festivities, and "Spend" has been substituted for the dismal password "Save" with refreshing results.

It is inevitable that an institution so dependent on public generosity as a voluntary hospital should suffer as a consequence of such a wave of economical depression: the suspension of the Great Appeal was sad evidence of this. Great courage must have been needed to launch another appeal, in this case to buy and equip the site for the new College, but the urgency of the call and the energy of its advocates have produced a goodly tale of bricks with such scanty straw.

Money is ill saved that shames its owner and, with the removal of the only cause that we can charitably assign to lack of support, we hope that more Bartholomew's men will interest themselves in the only vehicles that convey to those that have left an accurate impression of the work and activities of the Hospital. Figures reveal the lamentable fact that of nearly 4000 old Bart's men, only a bare 1500 subscribe to this Journal and less than 400 to the *Reports*. When the JOURNAL was first published in 1893 it had as its object, besides the recording of lectures and clinical work and the promotion of "a feeling of *esprit de corps* among the students", to quote from the first Editorial, that of "binding as much as possible the past

with the present, and to keep up the interests of old students in the doings of those now at the Hospital."

We for our part endeavour to make the articles and news of the greatest possible interest to the majority. The articles are, as far as is possible, practical in their application as well as instructive and entertaining. Attention is drawn to a series of short articles beginning in this issue with the title of "Clinical Methods". It is hoped that the series will be permanent, and its object is to record those "wrinkles, dodges and gadgets" which have been found of value in practice for diagnosis and treatment. Many of those working in the Hospital have agreed to contribute, but the success of the series will rest on the response of those outside. There is always a grateful welcome for contributions and news, or criticisms and suggestions of any kind from students and old Bart.'s men.

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The new issue of the *St. Bartholomew's Hospital Reports*, of which there is a review in the appropriate column, well maintains the high standard of excellence of its predecessors. We append a list of the articles:

- I. In Memoriam: W. Foster Cross, by C. E. West.
- II. The Problem of Peptic Ulcer. Introduction by Lord Horder of Ashford.
  - i. Observations on the Anatomy and Physiology of the Stomach. By Prof. H. H. Woollard.
  - ii. The Pathology of Peptic Ulcer. By Prof. E. H. Kettle.
  - iii. Duodenal Feeding in the Treatment of Peptic Ulcer. By Geoffrey Bourne.
  - iv. Results of Surgical Treatment of Gastric Ulceration. By W. Girling Ball.
  - v. A Survey of the Results of Treatment of Gastric and Duodenal Ulceration. By R. W. Raven.
- III. The Active Agent in the Treatment of Urinary Infections by Ketogenic Diet. By A. Q. Wells.
- IV. Papers on Anæmia in Infancy. (a) By Ian Jeffreys Wood; (b) by Alfred W. Franklin.
- V. Lectures on Toxic Goitre.
  - i. Anatomy and Physiology of the Thyroid Gland.
  - ii. Toxic Goitre.
  - iii. Treatment of Toxic Goitre. By Prof. Francis R. Fraser.
  - iv. The Surgery of Toxic Goitre. By Sir Thomas P. Dunhill.
- VI. Researches on the Ætiology of Goitre. By A. W. Spence.

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We extend a cordial and sincere welcome to the newcomers on the Senior Staff, Prof. L. J. Witts and Prof. Geoffrey Hadfield. The former we receive as a stranger in presence only, for many have availed themselves of the instruction given in his lectures and in his published work; the latter as an old Bart.'s man returning to his first home, whose work hitherto has been followed with much interest and great personal benefit.

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In the New Year's Honours a Baronetcy was conferred on Sir Holburt Waring, C.B.E., M.S., F.R.C.S. Prof.

Walter Langdon Brown, M.D., F.R.C.P., was created a Knight Bachelor, and Dr. Percy Brigstocke, M.B., M.R.C.S., L.R.C.P., was awarded the O.B.E.

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The freedom of the Society of Apothecaries was conferred on Prof. Langdon Brown at the Yeomanry dinner of the Society. Sir William Wilcox, who made the presentation, paid a tribute to his valuable work in research and as Consulting Physician to this Hospital.

\* \* \*

We omitted to announce in our last issue the appointment of Dr. James Maxwell as Assistant Director of the Medical Unit. He had been Acting Assistant since the resignation of Dr. Hilton in October.

\* \* \*

On February 18th and 27th and on March 4th Mr. J. E. H. Roberts will deliver the Lettsomian Lectures to the Medical Society of London. His subject is to be "The Surgery of Pleural and Pulmonary Infections". Mr. Geoffrey Keynes will introduce on February 25th a discussion in the same Society on the value and limitations of radium therapy.

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For the past twenty years there has appeared in the *Times* in the New Year a comprehensive review of the longevity figures which Mr. C. B. Gabb has collected from the front page and the news columns of that paper. He states that the deaths of 460 nonagenarians and 11 centenarians were recorded in 1934. Of the nonagenarians, 127 were men and 333 women (207 of these latter were married). There was only one man among the centenarians.

Mr. Gabb qualified from St. Bartholomew's fifty-six years ago.

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The frescoes on the staircase leading to the Great Hall have been thoroughly cleaned by a firm of experts. They were painted by Hogarth in 1736 in memory of his birth near the Hospital, and represent the Pool of Bethesda and the Good Samaritan. Smaller panels portray the dream of Rahere, the building of St. Bartholomew's and work inside the Hospital. Much of the detail of the paintings has been for a long time obscured by the grime of ages and difficulties of lighting, but skill and ingenuity have revealed their richness and nobility in a way hitherto unknown. Mr. Clark and his assistants are to be congratulated on the excellence of their delicate work, and gratitude expressed to Lord Bearsted and Lord Duveen for the generosity that has made the restoration possible.

## OBITUARIES.

## VISCOUNTESS SANDHURST.

**T**HE St. Bartholomew's Hospital Women's Guild mourns the death of its beloved Chairman, Viscountess Sandhurst, O.B.E., who died at her home, 60, Eaton Square, S.W. 1, on December 5th, 1934. She had not been well for some time, but we did not know her illness was serious.

She was Eleanor Mary, second daughter of Matthew Arnold and grand-daughter of Dr. Thomas Arnold, the famous Headmaster of Rugby. She married firstly the Hon. Armine Wodehouse, second son of the first Lord Kimberley, and had one son, the Rev. Roger Wodehouse, Vicar of St. Paul's, Oxford, and secondly, as his second wife, Lord Sandhurst, later Viscount Sandhurst, Treasurer of St. Bartholomew's. Her interest in the Hospital and in our Guild, over which she presided ever since it was founded in 1911, was deep and unflagging, and her services cannot be estimated. Under her guidance the Guild has grown from small beginnings to hold an important place in the organization of St. Bartholomew's. Her steady judgment, her charm of manner, her ready sympathy and her sense of humour are gifts invaluable to any career, and these were all hers. We shall ever cherish her memory.

We think the best tribute we can pay her is an increased zeal for the welfare of all that concerns our Hospital, for which she cared so much and worked so cheerfully.

The Committee and the "Bees" were represented at the funeral service at St. Michael's, Chester Square.

## R. FLETCHER MOORSHEAD.

St. Bartholomew's has lost one of its best sons in the death of Dr. R. Fletcher Moorshead, M.B., B.S., F.R.C.S., L.R.C.P., on December 4th, as the result of a rapidly fatal attack of double pneumonia. He qualified here in 1898, and took his Surgical Fellowship in 1903. Having to decline medical missionary work overseas owing to none too robust health, he set to building up in conjunction with Sir Alfred Pearce Gould, former Senior Surgeon to the Middlesex Hospital, the medical missionary organization of the Baptist Missionary Society, of which he was Medical Secretary, recognized as one of the first Protestant medical agencies at work to-day. Dr. Moorshead was an ardent advocate of the essential unity of spiritual and physical healing—an ideal well emphasized in his books, *The Way of the Doctor* (1926), and *Heal the Sick*

(1929). His magazine, *Conquest by Healing*, of which he was editor, embraces Protestant medical work in general, and gives a good bird's-eye view of medical work going on all over the world.

He was a great organizer, and his Dispensary in Shortt's Gardens, London, is a standing tribute to him, affording relief and inspiration to countless people.

He also founded four years ago the Missionary Association of Baptist Medical Students that meets regularly during term.

He did very useful work as a Clinical Assistant to the Ear, Nose and Throat Hospital at Golden Square.

He was always passionately fond of his *Alma Mater*, and was very keen to know of the latest progress of Bart.'s nowadays. He had Mr. McAdam Eccles as his colleague in many spheres of his labour. He was, then, a many-sided man and one whose death leaves the world definitely a poorer place. J. B. G. S.

## CHRISTMAS WARD SHOWS.

**F**OREIGNERS are apt to twit us for our moroseness and our lack of gaiety. The legend of our melancholy has persisted for centuries in France. Indeed, one visitor she sent us in the eighteenth century returned to tell his readers that the authorities in London took care to block up the approaches to the Thames in order that a glimpse of the river should not tempt their citizens to suicide. But it is not surprising perhaps that the abundance of English humour should be known only to ourselves, for its essence is its intimacy, and its good-humoured yet curious combination of tolerance and mockery. "The ludicrous takes hold of the English imagination and clings to it with all its ramifications," wrote Hazlitt. "We resent any difference or peculiarity of appearance at first, and yet, having not much malice in our hearts, we are glad to turn it into a jest—struck with oddity from not knowing what to make of it, we wonder and burst out laughing at the eccentricity of others, while we follow our own bent, and thus afford them, in our turn, matter for the indulgence of the comic vein."

That the comic vein is a structure found almost invariably in inhabitants of these islands would surely come to be the view of anybody who began his studies by visiting the wards of Bart.'s on any Christmas Day. Comedians spring up on all sides, topical songs and caricatures mingle with magic and melodrama. Talent often manifests itself in the most unlikely quarters, and for six hours during the afternoon a great deal of hard

work is done by all the players, who press on from ward to ward with their eagerly anticipated performances.

Each year these shows seem to become more ambitious in programme, costume, lighting and effects. As many

legendary in the matter of Christmas Shows, and his masterly hand was evident in the production of *The Blue Boarders*, which was the Resident's show. It was a model of its kind, attaining exactly the mixture of



as ten different troupes went the round this Christmas, and as the general standard was very high indeed, it is good to know that we shall have an opportunity of hearing the best numbers again in the Great Hall.

The name of Roger Gilbert has already become

intimacy, gusto and topicality at which every firm aims. The opening chorus immediately put people in the right mood, and Messrs. Wheeler, West and Ghey kept this up by a humorous sketch called "The End of the Match". Led by Hadfield, the company then showed that they



could do a non-frivolous song tunelessly, Latter's usual skill as an accompanist being much in evidence. A scene in a school contained some rather poor jokes, but Ghey's gustiness as the master and Gilbert's perfect portrayal of the 97-year-old "Harbottle" managed to make a success of it. The chorus song for everybody was well chosen and well produced; it was clearly an advantage for the audience to be able to see the words. We hoped for one of Gilbert's monologues, and when a sad figure appeared, announcing himself as "the chief of the anti-arson squad", we were not disappointed. Having heard, amongst other things, how he had found it essential to have rungs in ladders, we passed on to "Tommy Hayes' Party", a topical song set to a "Merrie England" air. It was one of the best items of all the shows, and we heard how various members of the Staff reacted to the party—either the noise was too great, their digestion was not good enough, it elevated their blood-sugar, made them break into North-country dialect, and so on. Altogether an excellent company. May "Rep. Omnia" be added to their Blue Board on January 19th.

Another contingent who achieved the right sort of intimate contact with their audience were *The First Floor Follies*, who incidentally were heralded by a poster deserving special praise. Newbold carried the weight of the show on his shoulders, and sang a song with amusing imitations of an old sow. When he sang "Kiss me, Dear", we were at first impressed by the back view of a nurse, but, as time went on, we would very much have liked her to turn round. "At St. Bartholomew's Hospital" was a good topical song, and two lightning sketches went down well, particularly the first. A sketch about a hole in the road was well acted, but would probably have been improved by being shorter. The success of the show was due in great part to excellent chorus-work and a good pianist.

To the strains of "Clap hands, here come Charlie's boys", *The Charlatades* made their rakish appearance in charge of a baby in a pram. Friedburg played both the mouth-organ and accordion with skill, while a scantily-clad leading lady danced to his music. "For England" was in the best style of patriotic melodrama. The villain held tightly to his moustache, but Richards, in a more heroic part, seldom seemed to have both beard and moustache on together at any one moment! The part of a naval captain was humorously acted by Dunn. There followed a duet which was too long, and a final effective, if rather lurid, chorus of charlatades led by Phillips singing triumphantly "With her Rectum underneath her Arm".

*The Senna Podians* gave a polished performance, and their costumes were exceedingly smart. An original

introduction was a loud-speaker, but it had the disadvantage of sometimes obstructing the view (though this was probably corrected in later shows), and of causing the otherwise excellent singers of a topical duet, "From my Window that Looks on the Square" to bury their faces in the microphone when we should like to have seen more of them. A fairy story acted with feverish activity was amusing, and Howell gave a hearty imitation of Mr. Girling Ball conducting a

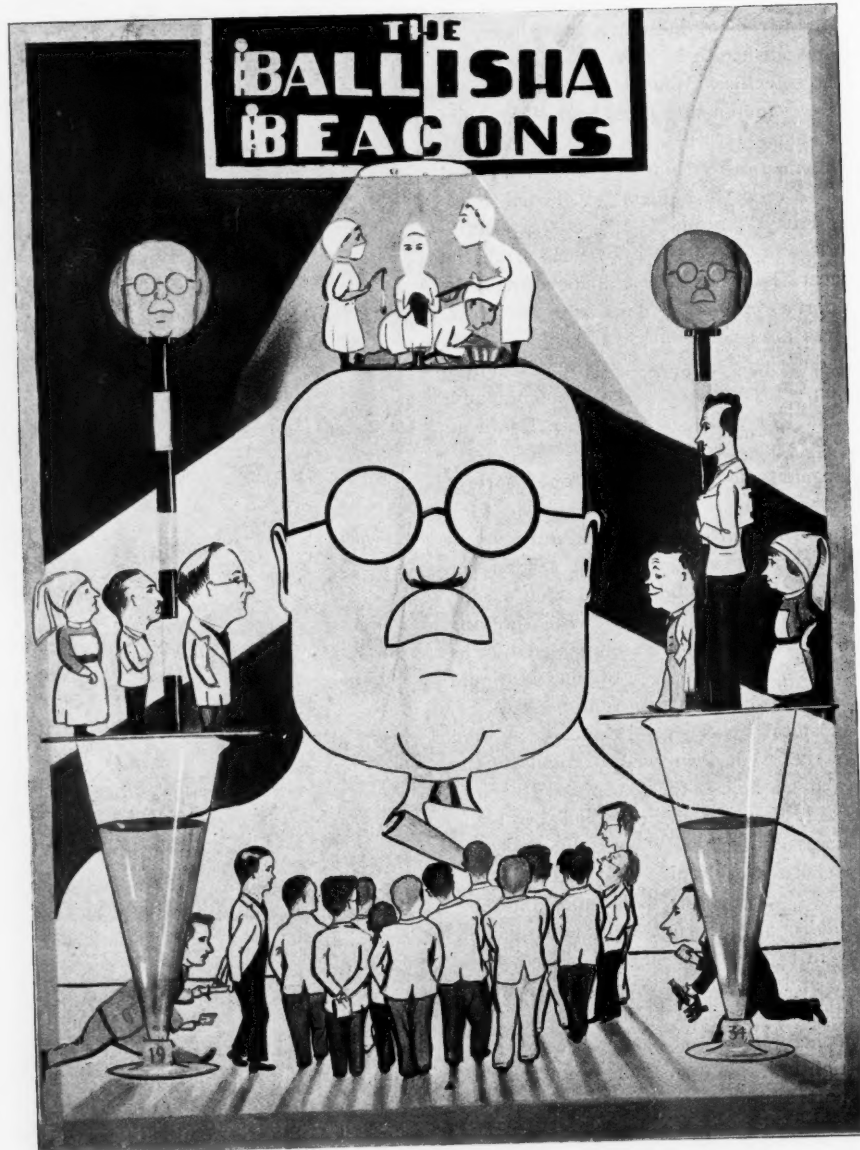


ward-round and reminiscing on his gall-bladder. Armstrong did unexpected things with oranges, and Herbert acted well. The wartime chorus songs were a safe choice, but a little hackneyed. The final tuneful chorus, "They wheeled him away with the greatest of ease, that funny old man with the unknown disease", was one of the best songs of the afternoon.

It was characteristic of *The Eclamptics* that they, too, had a microphone, but omitted to possess a loud-speaker. There was an air of craziness about the lightning imitations of such variegated celebrities as Schnozzle Durante, Dr. Donaldson, Herr Hitler, Mae West, Dr. Barris and several others. Whether it was the offer of

a "double-decker perambulator" as prize for the mother who identified most, or whether it was the skilful rapidity with which Beizer put the impersonations across, his complete lack of make-up and very slight

Schiller sang a song in the best (or worst?) American style, and gave a silent imitation of a traveller on the Underground at 5 p.m. This was one of the best turns of the Shows. The coffee-stall sketch was too slow.



voice-changes were hardly noticed. Surely, however, there are marked vocal characteristics about some of his subjects, which he might have introduced to complete the pictures. An excellent topical song commented on Dr. Shaw's memory for the Christian names of all his patients, and Dr. Beattie's enthusiasm for squash.

but Grant made a good conjuror, and slyly pulled the leg of his audience.

There was conjuring, too, by Clifford Smith, who also played the violin well in *The Blue Birds of 1934*. They began with an adaptation of "On Ilkley Moor baht 'at", which rather lacked punch for an opening number,

although the chorus were well together. There was a good topical song about the Surgical Unit, but their best item was a well-produced sketch in which Frost demonstrated the perils of being a pedestrian. The adventurous husband who, rather than riding easily in the Bentley, preferred "the thrill of walking", only succeeded in obtaining a pedestrian's licence after he had proved himself, amongst other things, completely noise-proof, shock-proof and curse-proof—yet even so, when first let loose, he ran straight into the inevitable Belisha Beacon. We look forward to seeing this again.

*The Green Chest-knits* performed very effectively in a Spanish setting. Prothero sang of "Frankie and Johnnie" in front of a portable bar-counter, and a silent drama was skilfully enacted behind him in order to prove the moral that "there ain't no good in men". A series of sketches about the interchange of professions went with a swing, as did a song touching on aspects of Mr. Roberts as a raconteur and Mr. Corbett as a motor-owner. "The Sunny Side" was a good song, but the chorus had not been trained in their movements, which were haphazard, and they did not look properly at their audience.

*The Ballisha Beacons*, on the other hand, fully understood the duties of a chorus, and in their opening number, "All good pals and jolly good company", they employed plenty of action, looked their audience full in the face, smiled hard at them, and generally radiated the atmosphere of the song. Their costumes were excellent. Two songs deserve special mention, "The Surgeon's name was Girling B, and he shouted for the sucker in Theatre C", and "We dropped the patient on the floor". A "levitation act" was as original as mysterious, and carols played by Moynagh on specimen-glasses were equally unusual. The melodrama was rather too slow, but Crowther distinguished himself in four parts simultaneously—those of the butler, the policeman, the heroine, sticking to her husband "through thick or clear", and the hero, who, deserting his fretwork for drink, took to the Saloon when his furious and somewhat fungus-faced father had intended him for the Bar. Ward led the chorus with admirable spirit.

*The Loose Livers*, considering their multi-coloured origin, were rather disappointing, but they sang and acted with great vigour. A sketch compounded from the titles of popular songs was one of their best numbers, as was "Over to Nurse", sung by Prewer and Fisk. Armstrong made a good sergeant-major.

I have deliberately postponed mention of *The White Hart Inn* until the end, because it was in a different category from the other shows. It was not a revue, it contained no modern songs, and there was nothing

topical about it. It was a parody of Victorian melodrama written by George Ellis and based on "The Streets of London". To attempt such an undertaking seemed, on the face of it, ambitious, but George Ellis is established as a C. B. Cochran of Bart.'s, and the cast which he gathered together were all experienced stars who understood exactly how the thing ought to be done. The costumes were first class, and the whole company deserve to be congratulated on their enterprise. Evans made a most successful if substantial heroine, who sang well and rent our hearts with such tragic lines as "I have no futuuh and the present it is a tortuuh", and by eventually attempting suicide in a portable gas-oven. The Dragon-like Bloodgood was truly villainous. His moustache, his cigar, his laugh and the hisses which he aroused all showed that he was a thoroughly bad man, whose only soft spot was his love for his "cheild" (portrayed alluringly by Macdonald). Messrs. Kingdon and Dorrell, representing Virtue, did valiant work in a fire scene, the effect of which was largely due to Gibson's performance on the piano. Gabb sang "Silver Threads among the Gold" melodiously if, perforce, somewhat powerfully for so senile a lady, while Gray, as the Innkeeper, and Hewlings as the Gipsy, both entered fully into their parts. It was to "The White Hart" that I first returned for refreshment when I had seen each of the ten shows.

But I would have missed none of them, for, although some were more stimulating than others, each had some tonic ingredient that the others lacked, and all of them were evidence of the ubiquitous existence of the particular brand of humour that is our own. "Christmas," says Robert Lynd, "is obviously either the happiest, or the most depressing time of the year, according to one's circumstances". If you were in Bart.'s on Christmas Day, you were one of the lucky ones.

E. C. O. J.

## CHANGING VALUES.



MEDICAL student's first contact with clinical medicine is a great event. After years of work spent in the study of pure science, during which a fairly solid foundation of knowledge has been laid, the goal is at last in sight. The preliminary subjects of chemistry, physics, biology and botany have already faded into the background. In passing they have claimed a few disciples, but the majority have passed on to the study of anatomy and physiology. These subjects are on the borderland of medicine, and they also claim a few adherents. But the majority of

medical students shut down on anatomy and physiology with a sense of relief on their first contact with clinical medicine in the surgery of a large hospital. Compared with human material anatomy is cold meat, and compared with practical work in the surgery physiology is too theoretical, and has too strong a flavour of frogs to hold the student's interest any longer.

It is interesting to reflect that although there is no dividing line between the normal and the abnormal, nevertheless, on one day as it were, the medical student closes his books on anatomy and physiology, puts on his white coat, and hardly realizing his complete change of outlook he turns his mind from an interest in the normal to the study of disease. At the same time what were people become patients, and what were personalities in ordinary life become composite beings now realized in terms of their component parts, or in terms of their complaints. Thus the importance of a man is his injured finger; the only interest in a woman is the inflammation of her breast; and if an infant claims attention to itself by persistent crying this is only the unreasonable barrage put up to prevent a proper examination of its throat or chest.

This sudden change of front is simply due to the fact that the study of injury and disease is the all-absorbing work from the first day in the surgery until the last professional examination has been passed. The new outlook which results is partly unconscious and partly the result of considerable effort. To the ordinary man, and especially to the young man, deformity is ugly and disease rather horrible. The sight of blood is sickening to some, and more so in circumstances which are "cold-blooded". Suffering, too, is always sad, and to a sensitive medical student it may be painfully so. Yet in a few days or weeks physical deformity assumes a new interest. The student is grateful to a friend who shows him a baby with six fingers on each hand, and he may go without his mid-day meal in order to see the supernumerary digit cut off. Disease soon loses its unpleasantness as it is analysed in terms of its location, its nature and its cause, while the prospect of its alleviation or cure by treatment is realized at once as one of the real joys in the practice of medicine. At a later stage, perhaps only after some years of practice, satisfaction is also to be found in attendance on quite hopeless illness, and indeed in easing the approach to death. These things, however, belong more to private practice, for in hospital practice most attention is likely to be given to those patients and to those diseases for which most can be done.

It is of course obvious that the first need of the medical man and the prime object of medical education is to recognize physical injury and organic disease. No

other member of the community than a doctor has the scientific training and clinical knowledge requisite for the diagnosis of disease, and without this special knowledge medical treatment (and *a fortiori*, surgical treatment) can hardly succeed. As a result the teaching of medicine is almost entirely concerned with the study of injury and disease. So much is this the case that the student is allowed, if not actually advised, to report the result of his examination of a healthy body in some such phrase as "nothing abnormal discovered", usually more shortly written "n.a.d.". The interest in disease as distinct from health is so overpowering that positives are expressed in the form of double negatives; a mucous membrane of normal colour is described as not anæmic or not pale, a well-nourished body is written up as not wasted, and a healthy-looking patient is said not to look ill. It may be natural caution or even the fear of making a mistake that is responsible for this curious terminology, as it prompts commercial firms to write the mysterious letters "E. & O.E." at the foot of their accounts. But as a matter of fact there is more to it than that. The medical mind in hospital and hospital-trained becomes obsessed with disease, and it is inclined to assume a cast of such one-eyed form that it sees in health only an absence of disease.

This has led to an interesting situation. There is on the one hand a lay public that wants health and knows something of it. A proportion of laymen give the subject of good health some special study, as for instance athletes, trainers of athletes and animals, breeders of live-stock and others, all of whom have a special interest in physical health. Again there are some who take an interest in the health of the mind, as for instance Christian Scientists, who make it their first concern, while religious bodies in general are also concerned with the health of the mind, though their first concern is the welfare of the spirit. On the other hand there is the medical profession, to whom the public goes for help when in need of health, although the chief interest of the profession is in disease. These objects, the public's desire for health and the profession's effort to cure disease, are not the same thing, even though they seem to be the same thing seen from different angles.

But now the difference between the lay and professional objectives has been realized, and medicine is taking steps to meet the public's need. The age-long interest of medicine has been in injury and disease. In recent times it embarked on the prevention of disease. Now it is taking another step forward, and is making the study and the achievement of health one of its principal aims. When this stage in the evolution of medicine is better established, the study of anatomy and physiology will be continued side by side with the study



of clinical medicine, and the present clear distinction between what is normal and what is pathological will cease to exist. The learning and understanding of medicine will be simplified by strengthening its physiological foundation, and in the cure or alleviation of functional disease at least, and perhaps also in the prevention of organic disease and structural change, a sound knowledge of normal function will provide the basis of medical treatment.

These few observations have been prompted by the approach of a new year, and it is perhaps excusable to offer a word of advice to those who are at an early stage of their clinical studies. Carry forward into medicine all the anatomy and physiology that you know, and continue to read and learn both subjects. Both medicine and surgery are built on anatomy, and there is much in clinical medicine that is a mere expansion of physiology. By the same token carry forward into your clinical work all your knowledge of human character and life. When you go into the wards at first you may be dominated by the sensation of something new and of which you are ignorant. The beds are indeed filled with patients suffering from injury or disease which is the subject for study, but they are also filled with ordinary people who need to be treated with kindness and respect; only on account of their infirmity they want extra care in addition to the professional attention you are able to give them. I believe that it makes the study of disease easier if there is carried forward with it a close study of health. It certainly helps the understanding of patients to realize them first as ordinary folk, and by doing this successfully the gap between hospital and private practice is much lessened.

It is in variations of health that there is the first warning of disease. It therefore follows that it is in the study of persons, the study of the habits of their bodies and the working of their minds both in themselves and in relation to their environment and to their undertakings, that the seeds of weakness and disease may be found. It is in this field that the study of health can be most profitably pursued.

GEOFFREY EVANS.

### AVE ATQUE VALE.

A mother's loss may craze her,  
May give the reft brain fits;  
But it's odd, when Bart.'s lose Fraser,  
That Guy's should lose their Witts.

## THE PATHOLOGY OF CORONARY OCCLUSION.\*

HERE would appear to be two main factors concerned pathologically in the production of a clot in a coronary artery. The first is local disease of the vessel, and the second a tendency to thrombosis.

Local disease of the vessel is not the more important of the two, for the majority of cases of atheromatous disease of the coronary arteries die without coronary thrombosis.

Attention must therefore be focused upon the question of a tendency to clotting.

Causes for the production of a local clot may themselves be general or local; an example of a general cause is seen in cases of acholuric jaundice, where splenectomy is known to be followed by local thrombosis in veins. Two cases of coronary occlusion, which I have recently seen, have drawn my attention to the possibility of the presence in cases of coronary infarction of some general cause of thrombosis. The first, a man of 54, suffered a typical coronary thrombosis, proved electro-cardiographically. During convalescence, six weeks after the onset of his disease, he suffered from a thrombosis of the right femoral vein. On consulting his oculist, after convalescence, he was found to have a small central scotoma, due to a small thrombosis in the right retinal artery.

The second patient, a man, *æt.* 78, suffered from a coronary infarction, proved electro-cardiographically. Four weeks previously he had suffered a sudden partial loss of vision in the right eye. This was due to a widespread thrombosis of the lower branches of the retinal artery.

On consulting the literature the following further two cases have come to light: Allan (1) reported the case of a man, *æt.* 39, who was admitted to hospital with a coronary thrombosis. At the post-mortem an old organized clot of the left subclavian artery, which had given rise to no symptoms during life, was found. Also the right renal artery was occluded by a recent red thrombus.

Watkins (2) reports the case of a woman, *æt.* 50. The history of pain was typical of coronary thrombosis, and pericardial friction was heard. No electro-cardiographic evidence was offered. Fourteen days after the attack a superficial thrombosis of the veins of the calf of the leg was noticed.

These cases of multiple thrombosis may be examples

\* A paper read at the British Medical Association meeting at Bournemouth, July, 1934.

of coincidence, and it would seem that obvious thrombosis elsewhere in the body is not a common complication. Levine (3) draws attention to hemiplegia as a sequela of the disease, and attributed it to embolism resulting from detachment of a piece of the mural intra-ventricular clot present in most cases during the healing process.

The case reported by Allan shows that thrombosis of quite large vessels may occur without marked symptoms. Personally I feel that local rather than general causes are likely to be responsible for the lesion, but until a sufficient amount of autopsy material has been carefully examined to discover the incidence of thrombosis in other parts of the arterial tree, the possibility of some general cause for clotting cannot be excluded. In order to exclude a general tendency to thrombosis a definite line of research is suggested. This would be along hematological lines. Biochemical and hematological investigation of the clotting process in blood taken from patients recently suffering from a coronary thrombosis is desirable, attention being particularly directed to the type of clot formed, the clotting time, the platelet count and the blood calcium content. Should this investigation also be followed by a negative result it will then be time to consider what local process, near to the diseased vessel, could initiate or predispose to the formation of a local clot.

The second point to which I would like to draw attention in a discussion on the pathology of coronary occlusion is one of definition. It is now widely held that cardiac pain in organic heart disease results from partial or complete interference with coronary flow, but the relationship between the pathological lesion found post-mortem and the type of cardiac pain suffered during life cannot be clear unless the type of pain is accurately defined. The term "angina" or "angina pectoris" is far too vague to be logically applicable, and its use should be discontinued. Patients suffer from coronary thrombosis, from angina of effort or from spasmodic angina. The morbid anatomy and the clinical diagnosis of the first of these, namely coronary thrombosis, has been fairly fully worked out.

The angina of effort is a quantitative symptom, pain being accurately proportioned to the effort undertaken. Since these two factors, pain and effort, vary directly with one another, it would seem that there must be a constant factor in the equation. This factor is presumably the decreased lumen of the coronary branch. Since this partial occlusion produces pain after a definite given amount of exertion in any one case, its degree is presumably constant, or only very slowly variable. Spasm of the vessel here is thus unlikely.

Cases of angina of effort who have died should be examined post-mortem with this history in mind. It should be determined in such cases whether atheroma of a coronary artery or syphilitic obstruction to its mouth is invariably present.

In spasmodic angina a further factor enters in. Angina of effort has generally been present for months or years before the onset of spasmodic angina. These new acute sudden attacks would appear to be the result of the presence of some further factor. It is unlikely that repeated small occlusions are responsible; a patient under my care had attacks for three to four years, to a number of two to three a day. If occlusion were the cause there would be no patent arteries left in the heart in such a case. The question as to whether these sudden attacks are due to spasm remains to be answered. A man, *æt.* 42, was under my care at St. Bartholomew's Hospital. He had suffered from angina of effort for about fifteen months. A few months previous to admission he had begun to get attacks of spasmodic angina. He was also a severe diabetic, and whilst under treatment he died. At the post-mortem examination atheroma of the left coronary artery was found. There was no sign of old or recent coronary thrombosis. The lumen of the artery was narrowed, but the vessel was still easily elastic throughout its course. There was no absolute rigidity from severe calcification.

It was thus theoretically possible that the earlier symptoms of angina of effort were due to the smaller lumen, resulting from arteriosclerosis, and that the attacks of spasmodic angina which arose later were the result of spasm in the not yet rigid vessel.

Whether such a simple explanation as spasm of the vessel is sufficient to account for attacks of spasmodic angina is debatable. But the theory cannot be excluded except by the careful correlation of a sufficient series of post-mortem findings with the previous clinical history of the cases. Such a correlation will remain impracticable unless the loose term "angina" is given up.

My opinion is that all cardiac pain, due to organic disease of the heart, with the exception of heart consciousness and the dull ache found in some cases of mitral stenosis, is to be classified under one of the three heads, coronary thrombosis, angina of effort, and spasmodic angina, and that all three are due to interference with coronary flow, permanent or transitory, partial or complete.

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Geoffrey Bourne.

## DENTAL CYSTS AND EPITHELIAL ODONTOMES: THEIR PATHOLOGY AND TREATMENT.

### REVISED DEFINITION OF AN ODONTOME.

**U**NTIL recently dental cysts have always been classified, by writers of authority in books on general surgery, among the odontomes—an odontome being defined as a "tumour composed of dental tissues". But a cyst does not conform to the surgical definition of a tumour; so that if dental cysts are still to be included among the odontomes, the definition of an odontome must be enlarged to include "any abnormality of excessive growth derived from the dental formative organs" (Sprawson).

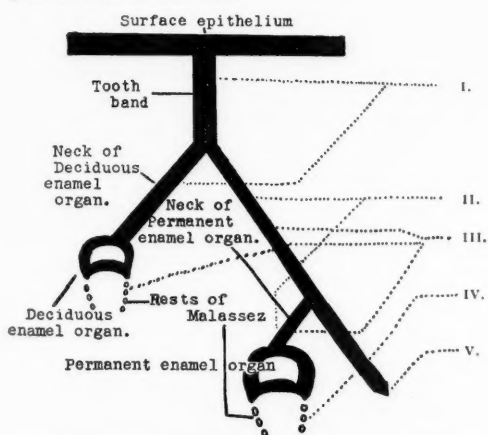
### CLASSIFICATION OF EPITHELIAL ODONTOMES.

The epithelial odontomes develop abnormally from the dental epithelium only, and are subdivided into—

- (a) Cysts of eruption.
- (b) Dental cysts.
- (c) Dentigerous cysts (follicular—Bland-Sutton).
- (d) Multilocular cysts (adamantinomata).

### PATHOLOGY.

In order to understand more easily from which dental epithelial cells the various epithelial odontomes originate, I refer my reader to Diagram I. This represents the epithelium of the gum and its downgrowth forming the tooth band, from which arise the deciduous and permanent teeth buds.



I.—DIAGRAM OF NAMED PARTS OF EPITHELIAL DENTAL FORMATIVE ORGANS (FROM EVELYN SPRAWSON).

Site of cells which probably give rise to: I. Cyst of eruption over a deciduous tooth. II. Cyst of eruption over a permanent tooth without predecessor; dentigerous cyst enclosing permanent tooth without predecessor (rare). III. Dental cyst on deciduous tooth; dentigerous cyst enclosing permanent with predecessor. IV. Dental cyst on permanent; dentigerous cyst when it tracks back and encloses a third molar (rare). V. Multilocular cyst ??

### (a) Cysts of Eruption.

Very small cysts of eruption are quite commonly seen in infants and young children as blue blobs overlying an erupting tooth—they have the same appearance as a small blood blister. Cysts of eruption may occur, however, over any tooth, deciduous or permanent, where the normal eruption is delayed.



FIG. 1.—LARGE CYST OF ERUPTION, involving upper wisdom tooth displaced high above tuberosity of maxilla. (Cowan.)



FIG. 2.—CYST OF ERUPTION, involving a misplaced upper central incisor.

In the normal process of eruption of a tooth the epithelial remnants of the tooth band, superficial to the tooth in question, degenerate, and so open up a path for eruption. The prolonged stimulus of delayed eruption causes a reversal of the normal process—a proliferation instead of a degeneration of these epithelial remnants—and the result is a cyst. In the early stages cysts of eruption are *not* infected; but, as they increase in size and their walls become thinned, they are almost certain to become so secondarily.

Large cysts of eruption (Fig. 1), containing up to 10 c.c. of fluid, frequently occur over wisdom teeth.

Clinically they are identical with dentigerous cysts, but their origin is different. The wisdom teeth have no predecessors; and the presence of cysts over them goes



3



4

FIG. 3.—A GRANULOMA, on a root-filled upper second premolar, pushing up the floor of the antrum of Highmore.

FIG. 4.—A LARGE LOW-DIPPING ANTRUM, easily confused with a cyst, and often accidentally opened in extraction of upper molars.



FIG. 5.—DENTAL CYST OF THE MAXILLA, arising from second bicuspid (absent), and extending back to the tuberosity, obliterating the antrum.

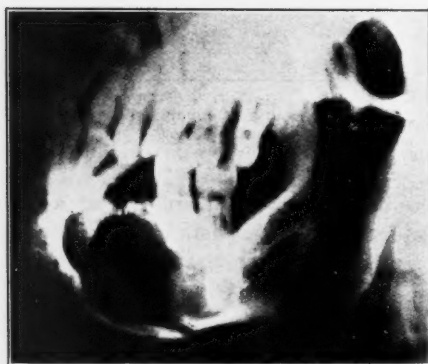


FIG. 6.—LARGE DENTAL CYST OF THE MANDIBLE resulting in pathological fracture.

far to support the view that delayed eruption, so common in wisdom teeth, is the exciting cause of epithelial proliferation and cystic formation (Fig. 2).

#### (b) Dental Cysts.

Dental cysts generally arise from the epithelial remnants of the tooth-bud found at the apices of either deciduous or permanent teeth. These epithelial remnants are known as the "rests of Malassez", and are actually the remains of the epithelial sheath of Hertwig.

In the case of a deciduous tooth, however, the cyst may also arise from the part of the tooth band, deep to the deciduous tooth, which went to form the permanent successor (see Diagram 1).

In both cases the exciting cause of the epithelial proliferation is either (i) infective—a dead pulp or chronically inflamed periodontal membrane—by far the more common—or (ii) traumatic—trauma sometimes causing proliferation of the rests of Malassez without death of the pulp.

The apical granuloma (Fig. 3) is the early stage of a dental cyst. But it does not follow that all granulomas become cystic; many break down and form abscesses, or they may remain quiescent indefinitely. It has been proved, however, that *all granulomas contain bacteria*—generally streptococci of the *viridans* group—and also the walls of dental cysts, although their contents may be sterile (Arthur Bulleid). A large cyst with thin, distended walls almost invariably ends in acute or chronic suppuration, and as a result is frequently misdiagnosed.

Dental cysts are quite common on milk teeth, and only less common than on permanent teeth because of the long time cysts take to develop. *When the dental cyst, arising from a milk tooth, involves the crown of its permanent successor, a dentigerous cyst is formed.*

It has been proved that neither cysts of eruption nor dentigerous cysts can arise from the actual enamel organ—as previously taught—because the crown of the tooth projecting into the cyst is always covered by an intact Nasmyth's membrane, itself the remains of the enamel organ.

Radiographically it is quite easy to confuse a large, low-dipping antrum (Fig. 4) with a dental cyst. Fig. 5 shows a large dental cyst of the maxilla obliterating the antrum. Fig. 6 shows a pathological fracture of the mandible due to a large dental cyst in the premolar region.

#### (c) Dentigerous Cysts.

As previously stated, dentigerous cysts are pathologically identical with dental cysts, except that the cyst meets and wraps itself over the crown of the permanent successor, and, by its tension, displaces or prevents the latter from erupting normally. Clinically there is, therefore, a permanent tooth missing from the arch in the region of a cyst. They occur most frequently





FIG. 7.—A CYST IN THE UPPER CANINE REGION CLINICALLY SIMULATING A DENTIGEROUS CYST. The milk canine is present, but the permanent successor is not visible—it is lying above the roots of the bicusps.



FIG. 8.—A DENTIGEROUS CYST OF THE MANDIBLE, arising from second deciduous molar, involving second premolar. (Sprawson.)

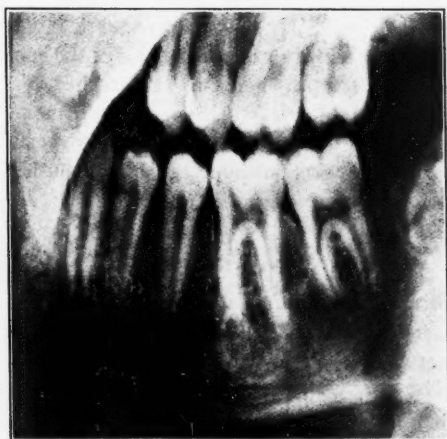


FIG. 9.—SAME AS FIG. 8. DENTIGEROUS CYST. Four years after operation. The second premolar has erupted into perfect position. No sign of cyst. (Sprawson.)

in the canine and premolar regions in subjects under twenty years of age.

Fig. 7 shows a dental cyst in the upper canine region clinically simulating a dentigerous cyst.



FIG. 10.—MULTILOCULAR CYST OF THE MANDIBLE extending from canine to coronoid process. All teeth standing.

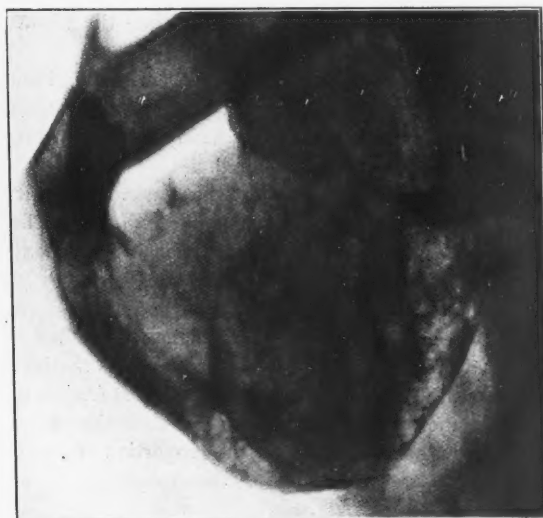


FIG. 11.—MULTILOCULAR CYST OF MANDIBLE—recurrence and involvement of tissues of neck. Some thirty years' duration. Had been excised locally many times, but always recurred.

Fig. 8 shows a large dentigerous cyst in the mandible involving the second premolar. This was discovered at an age when the involved successor was still due to erupt and was not displaced.

Fig. 9 shows the same case four years later—involved tooth in perfect position and no sign of the cyst. The cyst was opened and kept open by an obturator; but

most of the cyst lining and the involved tooth were left intact. I thank Dr. Evelyn Sprawson for permission to reproduce this case.

(d) *Multilocular Cysts (Adamantinomata).*

According to Bland-Sutton, "the multilocular cyst arises from the enamel organ; and histologically it consists of branching and anastomosing columns of epithelium, some of which form alveoli. The cells vary in shape, the outer ones being columnar, while the central cells degenerate and resemble the stellate reticulum of the enamel organ".

To discount this view the following facts are evident:

(1) The age-incidence of multilocular cysts is at about thirty years. If the cysts arise from the enamel organ, they ought to occur in the young.

(2) Calcified dental tissues have never been found in multilocular cysts; and the columnar cells found lining them are not at all like ameloblasts.

(3) In many cases (Fig. 10) the whole dentition has erupted normally, and the cyst lies beneath the teeth. Where the wisdom has been found involved in the cyst, the cyst more likely began to form before the wisdom was due to erupt.

(4) If a portion of the cyst lining is removed and sent to a pathologist for microscopical examination, without stating the locality, the section is nearly always reported to be a "basal-celled carcinoma".

(5) Sprawson has pointed out the marked similarity under the microscope of (a) rodent ulcers, (b) epithelial tumours of the anterior portion of the pituitary body, and (c) multilocular cysts of the jaws.

Their probable origin is an actual ingrowth of the gum epithelium, with a local malignancy similar to rodent ulcers. Fig. 11 is a good example of the local malignancy of these cysts. They occur most frequently in the mandibular third molar region, at the age of thirty years, and in females in the proportion of two to one male.

*The Lining Membrane and Contents of Cysts of Eruption, Dental and Dentigerous Cysts.*

The type of lining membrane seems to depend on the age and size of the cyst. In small cysts of eruption and in small dental cysts on deciduous teeth of short duration, the lining epithelium is many layers thick; the cells are spheroidal on the outside and stellate on the degenerative cystic side; also the fibrous wall contains many cells and the blood-supply is free.

The larger the cyst and the greater the tension, the thinner the lining epithelium, which appears stratified

or even squamous. The fibrous tissue bounding the cyst becomes bloodless and thicker.

The contents vary from a translucent straw- or brown-coloured fluid, sometimes viscid, to a semi-solid cheesy mass. Cholesterin crystals are nearly always present in the fluid. The contents are usually sterile.

DIAGNOSIS.

I do not intend to discuss the history, signs, symptoms and differential diagnosis of epithelial odontomes or cysts of the jaws, but will content myself by stressing the importance of very careful examination of all swellings of the jaws, inflammatory or painless, no examination being complete without X-ray evidence. Many small cysts are discovered only by the routine dental X-ray examination—they give no signs or symptoms. The large cyst is fairly obvious, unless purulent and masked by the additional signs of acute inflammation.

TREATMENT.

(A) *General.*

*All cysts, except multilocular, must be opened and kept open or else completely excised.*

If they are left alone they will gradually increase in size; when large, containing 10 c.c. of fluid or more, they may cause serious symptoms and disability due to the pressure on, and displacement of, surrounding structures; they cause disfigurement, and are very liable to become acutely infected, leading to cellulitis of the face and neck.

If the cyst is not acutely infected, all other sepsis in the mouth should be eradicated before operating on the cyst itself, and a week allowed in between for sockets, etc., to heal. Any root or tooth involved in the cyst is best left *in situ* until the time of the operation.

The anæsthetic of choice is endotracheal gas and oxygen; but if necessary the operation can be done quite painlessly under regional block novocain 2%, helped by 1½ to 3 gr. of nembutal given by mouth half an hour before commencing.

(B) *Detailed.*

(1) SMALL SURFACE CYSTS OF ERUPTION, over milk or permanent teeth which are erupting normally, need only be punctured or incised.

(2) CYSTS OF ERUPTION OR DENTIGEROUS CYSTS.—  
(a) *Where the tooth involved is at its normal age for eruption, and is not displaced or impacted.*

First the infected deciduous tooth, if present, is extracted. Then a fairly large opening is made into the

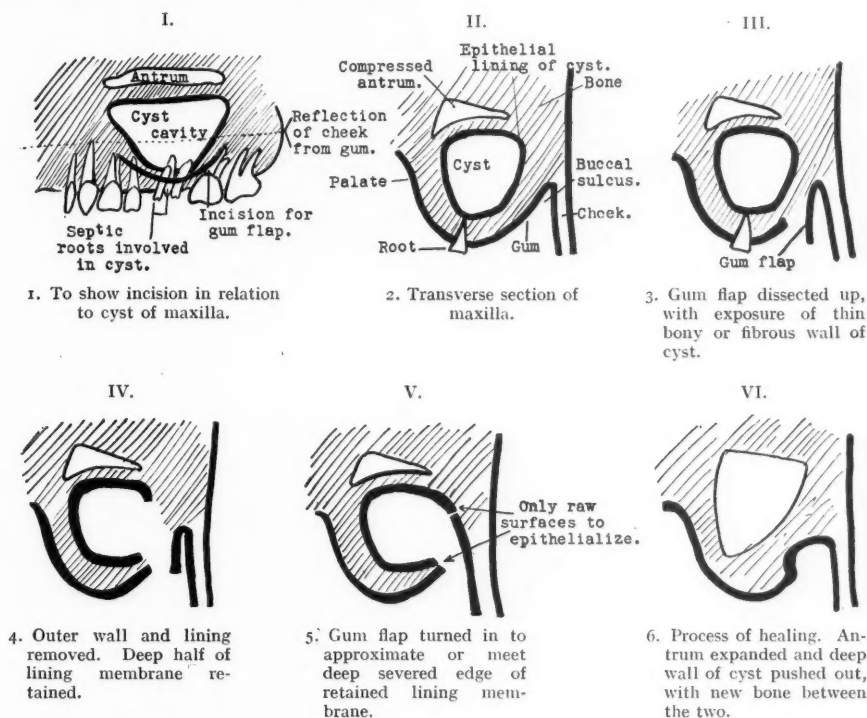
cyst over the erupting tooth, the surface segment of gum and cyst lining is excised, and then means taken to keep the opening patent—if necessary by a plug or obturator of vulcanite. The erupting tooth and deep part of the lining are left undisturbed, and the tooth will eventually erupt into normal position (Figs. 8 and 9).

(b) *Where the tooth involved is past the age for normal eruption, or is displaced or impacted.* The gum covering the cyst is incised and reflected, as in Diagram II. A large opening is then made into the cyst and the tooth removed. If possible this should be done without

the wound can cease. In fact the process may mean many weeks of disability for the patient.

3. DENTAL CYSTS.—(a) *Small dental cysts, up to half an inch in diameter*, can be dealt with by first extracting the tooth or root—if present—from which the cyst originated, then by reflecting the gum in the buccal sulcus and removing the bone covering the outer wall of the cyst, removing the cyst lining entire, allowing the cavity to fill with blood, and finally by stitching the edges of the wound together.

(b) *All other dental cysts*, whether sterile or infected,



II.—DIAGRAMS OF SURGICAL TECHNIQUE FOR DENTAL CYSTS (AFTER E. B. DOWSETT.)

removing the deep part of the lining membrane with it; but this will be found difficult to accomplish, because the membrane is often firmly attached round its neck.

If the tooth can be extracted without disturbing the deep part of the lining, so much the better; it then only remains to keep the opening patent while the raw edges epithelialize.

But if the whole lining is removed a large raw cavity is left, with rigid bony walls. This is generally too large a cavity to hope for healing by organization of blood-clot, and the wound cannot be closed with stitches; consequently the raw cavity must be packed and is liable to turn septic. It has to epithelialize over its whole surface, growing in from the gum edge, before dressings of

and, if possible, all cysts of the jaws except multilocular, I treat as follows (see Diagram II).

*Operative procedure.*—First the tooth from which the cyst has originated, is extracted. Then a large half-moon incision is made through the gum on the buccal side, starting from behind at the limit of the cyst and at the reflection of the cheek from the jaw, and carried forward to the anterior limit of the cyst. The curve of the incision is towards the alveolar ridge, and must come within a quarter of an inch of the alveolar crest, but not on to it—the crest must be carefully preserved so that any denture or prosthetic appliance made later may have a good foundation.

The gum is then reflected as a flap, separated from the outer wall of the cyst and carefully preserved.

Next the outer wall of the cyst, including bone and soft tissues, is excised to its widest limit, leaving the inner half intact with its membrane.

The operation is then completed by turning in the gum flap. The flap must not overlap the lining, and if too long, must be pared; if a little short it does not matter. *The cavity is packed with paraffin gauze for twenty-four hours only to check any hæmorrhage, and to press the raw under-surface of the gum flap against the raw deep edge of the cavity.*

When the packing is removed the flap will usually be firmly adherent to its new position, so that the opening is now raw at the alveolar edge only. There is scarcely any after-pain.

By leaving the inner half of the cyst-lining intact and turning in the gum flap, the raw alveolar edge is the only part of the wound which has to epithelialize, and this will be healed within two weeks. From the second day the cavity only needs gentle syringing to prevent the collection of debris; the cavity itself is quite clean, and after a few days the syringing can be done by the patient.

A point of interest is the rapidity with which the inner wall of the cyst is pushed out by the formation of new bone around and behind it; this naturally takes place more quickly in the mandible than in the maxilla, but in the maxilla the expansion of the antrum pushes out the cyst and compensates for the lack of bony growth.

In the maxilla, as shown in the diagram, a large dental cyst may completely fill the site normally occupied by the antrum of Highmore, the latter being flattened against the side of the nose. After this operation, where particular care has been taken to leave the inner lining of the cyst intact, the nasal pressure expands the antrum once more, and in doing so helps to push out and obliterate the cyst cavity.

On the other hand, if the whole cyst lining is removed, the odds are that the antrum will be opened at the same time—an unnecessary and tiresome complication.

If a large maxillary dental cyst contains pus and has been chronically infected for some time, the antrum is almost certain to be infected as well. These are the only circumstances under which I deliberately puncture the inner wall of the cyst, and thus effect drainage of the antrum.

4. MULTILOCULAR CYSTS.—Unless every scrap and cell of the cyst lining are removed, multilocular cysts will recur locally.

Radium or X-ray treatment does not meet with success. It seems, therefore, that partial excision of

the jaw is the only certain cure, followed later by a bone-graft.

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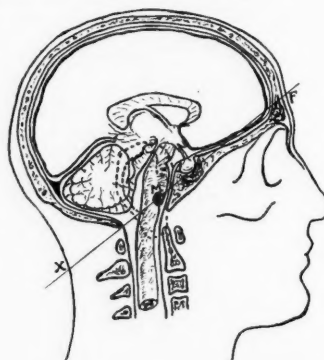
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GEORGE T. HANKEY.

## CLINICAL METHODS.

### CISTERNAL PUNCTURE.

Puncture of the cisterna magna may be required for diagnostic or therapeutic purposes. A specimen of the cerebro-spinal fluid can almost always be obtained by lumbar puncture, but the diagnostic value of cisternal puncture depends upon the information which may be obtained by comparing manometric readings of the pressure of the fluid in the cisterna magna with that in the lumbar subarachnoid space when a block in the spinal subarachnoid space is suspected, and also upon the possibility of localizing the site of the block by injecting heavy lipiodol into the cisterna magna and taking a radiogram with the patient in the upright position. Cisternal puncture may be helpful in the treatment of meningitis, being used both to drain off infected cerebro-spinal fluid, and to inject the appropriate therapeutic substances.



To reach the cisterna magna the needle must pass through the posterior atlanto-occipital membrane, which is considerably thinner than the ligamenta flava between the laminae of the lumbar vertebrae. A rather more delicate “touch” is therefore required to recognize the sensation of piercing this thin membrane with the needle. The only important structures situated posterior to the membrane are the vertebral arteries, but, as they curve round its lateral borders, if care is taken to keep the needle in the middle line the vessels run very little risk of injury.

In sagittal section the cisterna magna is almost triangular in shape, with the apex of the triangle pointing downwards. It thus comes about that the distance from the posterior rim of the foramen magnum to the posterior surface of the medulla oblongata measures just over 1 cm., whereas the lowest point of the medulla is only 0.5 cm. from the posterior arch of the atlas. It is therefore important to make the puncture as close to the upper edge of the atlanto-occipital membrane as possible and to incline the needle upwards.



The patient may be placed lying on the left side or sitting upright; in either case the head must be held erect or only very slightly flexed. The skin having been cleaned with spirit, the left index finger of the operator is placed upon the prominence of the spine of the axis vertebra, the uppermost bony point palpable in the mid-line at the back of the neck. The tissues should be anasthetized with a 1% solution of novocaine and adrenalin or with novotox, a small weal being made in the skin with a fine hypodermic needle just above the tip of the left index finger, at the point X in the diagram, and a longer and stouter needle being used for infiltrating the deeper layers.

The needle used for puncturing the cisterna magna should be a fine lumbar puncture needle with a very short bevel at its point. It must pierce the skin in the middle line at the point X just above the level of the spine of the second cervical vertebra, and should pass forwards and upwards in a line which runs through the external auditory meatus (M) and cuts across the forehead at a point (F) about 3 cm. above the glabella. If the puncture is correctly carried out the needle should first strike the occipital bone just behind the foramen magnum, and when the correct depth is thus ascertained the needle should be withdrawn, directed slightly downwards, and re-inserted so that it just slips in close below the rim of the foramen magnum. The sudden diminution in resistance after the posterior atlanto-occipital membrane and the dura have been pierced may be felt distinctly, but in order to run no risk it is well to pass the needle in for a short distance at a time, withdrawing the stylet at frequent intervals so as to avoid passing the point unnecessarily far into the subarachnoid space. If this line is followed there is an average distance of 1.5 cm. between the puncture in the dura and the medulla, so that the margin of safety is considerably greater than it would be if a more horizontal line were used.

In the average adult neck the dura is reached at a depth of 4.5 cm. from the skin surface, but in a child's neck the distance will be much shorter than this, whereas in a fat and muscular person it may be as much as 6 cm. It is therefore clear that, as in the case of all such punctures, angles and measurements may be misleading, and the only reliable method is to *feel* the way in. J. P. R.

## THE NURSING OF PATIENTS WITH HYPERTHYROIDISM BEFORE AND AFTER OPERATION.

THE consideration of the management of a case of toxic goitre during the period of the operation presupposes an adequate course of preliminary medical treatment, and this article is intended to deal with the nursing of patients suffering from hyperthyroidism only during the time immediately before operation and until the stitches are removed.

### DIET.

This should be liberal, containing protein of the less stimulating varieties (e.g. fish, eggs, white meat), sufficient raw fat to supply the necessary vitamins, and a great deal of carbohydrate. The patient should be encouraged to drink large quantities of water, and extra carbohydrate can be given in the form of glucose in orange-juice and lemonade.

### REST.

It is imperative that before the operation the patient should have at least one good night's sleep. Luminal gr. j, or medinal gr. viiss, given about 6.30 p.m., has been found useful in this respect, while in difficult cases hypodermic injections of heroin or morphia may be required to ensure sleep.

### MEDICATION.

This is not, strictly speaking, a nursing point, but it is worth remembering that Lugol's solution is more efficacious when given in milk than when given in a watery solution.

The routine preoperative treatment carried out in the wards of the Surgical Professorial Unit is as follows:

Two days before operation the patient is weighed. The intake of food is diminished slightly so as to avoid any "heavy" or

indigestible substances, and the intake of fluid is increased. A mild aperient is usually administered, but if there has been any tendency to looseness of the bowels this may wisely be omitted.

On the evening before operation a soap and water enema is given.

### DAY OF OPERATION.

#### For operation 9 a.m.

- 5 a.m. Tea. Barley-sugar to eat.
- 6.30 a.m. Lugol's solution,  $\text{mxxx}$  in milk.
- 7 a.m. Morning toilet.
- 8 a.m. Preoperative injection (morphia gr.  $\frac{1}{2}$ , or morphia gr.  $\frac{1}{4}$  + atropine gr.  $\frac{1}{100}$ ).
- 8.15 a.m. Avertin given slowly *per rectum*, taking 20-30 mins., using a No. 8 or No. 9 catheter. Catheter to be left in rectum, spigot inserted and strapped to buttock.

#### For operation 1.30 p.m.

- 6 a.m. Tea and toast.
- 7 a.m. Morning toilet.
- 10.30 a.m. Glucose  $\text{ij}$  in  $\text{3viiij}$  orange-juice and water; barley-sugar to eat.
- 11 a.m. Lugol's solution,  $\text{mxxx}$ .
- 12.30 p.m. Preoperative injection.
- 12.45 p.m. Avertin.

*Note.*—If the avertin solution is dispensed overnight it should be warmed by standing the bottle in a bowl of water, T.  $120^{\circ}$  F., for  $\frac{1}{2}$  hour. At the end of the procedure the patient is usually asleep, and the head should be turned on one side to prevent saliva collecting in the mouth. Operation garments should then be put on, eyes bandaged and ears covered with pads of wool.

Moving the patient to the theatre may rouse her slightly, but any conversation carried on at this time is completely forgotten later when she is fully conscious. It is always wise for a nurse with whom the patient is familiar to be in attendance until the local anæsthetic has been injected and gas and oxygen anæsthesia is established, in case there should be this semi-conscious phase.

### AFTER OPERATION.

The bed will be prepared for the reception of the patient as follows:

- 1 pillow for the head.
- 1 sheet, to cover the patient.
- 1 quilt,
- 1 thin blanket if desirable (in cold weather or for elderly patients).
- 2 bedsides.

Hot-water bottles are never required, and are, in fact, harmful, and a blanket must not be placed next to the patient. If the patient is extremely toxic, or the weather warm, a cradle may be necessary, and an electric fan near the bedside is also helpful.

On return to the ward, the patient must be lifted into bed with great care, the head and neck being supported all the time. The bedclothes should not be tucked in, as this tends to aggravate restlessness, but should be draped over the bedsides (Fig. 1).

A rectal saline ( $\text{3v}$  to  $\text{3viiij}$ ) containing Lugol's solution  $\text{mxxx}$  should be given immediately, the saline being regarded as a vehicle for the iodine, except in cases where there has been much loss of blood, when a larger quantity of fluid may be ordered. The pulse-rate is recorded hourly during the first day, and 4-hourly subsequently.

As soon as possible, depending on the patient's condition, she should be propped up with a knee pillow to prevent her slipping down (Fig. 2).

As soon as swallowing is possible, the patient's usual dose of Lugol's solution should be administered by mouth. Fluids should be given freely, e.g. iced water, glucose water, orangeade or lemonade with glucose.

Mucus in the throat is sometimes troublesome, and the patient should be encouraged to give one good cough occasionally and to try to get it up. For this reason occasional doses of heroin have been used successfully to control restlessness without causing a deep sleep and loss of the coughing reflex.

A mixture containing aspirin gr. x and phenacetin gr. v (without caffeine) is invaluable in relieving the pain of swallowing, and during the first few days is usually ordered half an hour before the

principal meals of the day. Luminal gr. j is usually given about 6.30 p.m. on the evening of the operation day. An injection of heroin gr.  $\frac{1}{4}$  is usually required at 8 p.m. or 9 p.m., and may be repeated when necessary.

Patients vary considerably as regards the food which they can manage to take on the day following operation. Some will have fluids only, and so long as an adequate quantity is taken one is satisfied. Most of them enjoy ice cream or jelly at this stage, while others feel hungry and will eat minced chicken, mashed potato and gravy, custard and thin bread and butter. In a very short time this is gradually increased until the preoperative diet is reached.

If necessary, a mild aperient is given on the evening of the second day after operation.

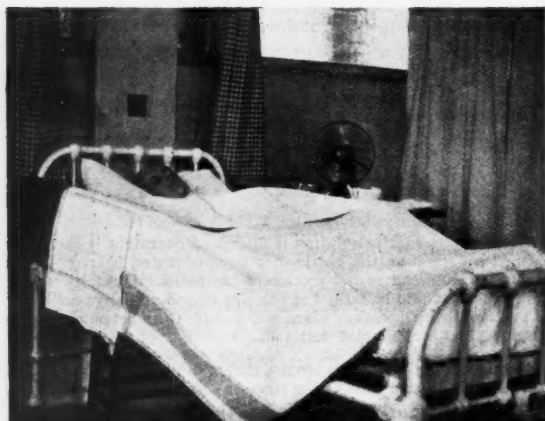


FIG. 1.—PATIENT SHORTLY AFTER RETURN FROM OPERATION THEATRE.

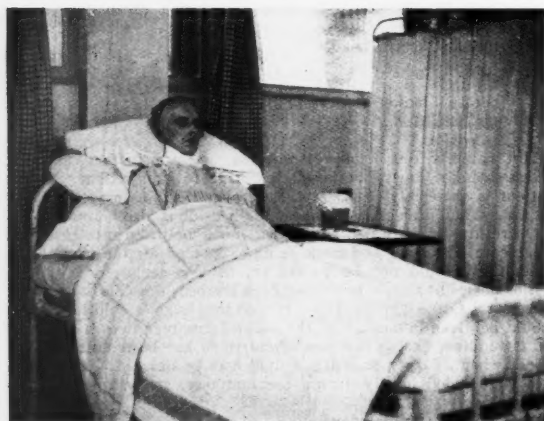


FIG. 2.—PATIENT ON DAY AFTER OPERATION.

#### DRESSINGS.

The first dressing is done on the evening of the operation day, to make the patient more comfortable and to observe if there is any discoloration or puffiness of the flaps indicative of oozing.

On the evening of the day after the operation the drainage-tubes are removed, and on the third evening the stitches are removed. The only exception to this rule is the uncommon case in which the operation has been performed in several stages, when it may not have been possible to suture the platysma. Under such circumstances the skin sutures should be left for five days.

#### GENERAL MANAGEMENT.

In a general ward it is advisable to arrange the beds so that patients with hyperthyroidism are not near one another.

Quietness and avoidance of any excitement are essential. Visitors tend to agitate these patients to a marked degree, and the co-operation of the relatives is very necessary in the attempt to remove all exciting factors.

I am indebted to Miss Vaughan for the accompanying photographs.  
M. B.

### NONE SO BLIND.

AS we entered the courtyard of the Doctor's Cave Hotel we were surprised to see our acquaintance Mr. Harrison seated beside his baggage. Only the previous evening he had talked to us and said nothing about his leaving; in fact we understood he intended to remain at this famous Jamaican bathing-place for several weeks longer.

We were surprised and sorry at his going, and said we hoped that his sudden departure was not due to any bad news from home.

In reply he invited us to sit down while he explained to us exactly what had happened to cut short his visit; for the station bus was not due to call for him for another ten minutes.

He told us, what we already knew, that he had been staying at Montego Bay for several weeks and intended to remain there until the weather became too hot, when he would return to the States.

Owing to something which had happened the night before he was leaving at once, to embark at Kingston on the first steamer bound for New York.

During his visit he had not made many friends, or mixed much with the other hotel guests. But he had made two friends, both ladies, both young, and both, in their different ways, charming. One of these two he used to meet every morning on the beach; and after bathing they used to sit and talk until it was time to return to the hotel for lunch. He did not know the lady's name nor where she was stopping; probably she stayed at one of the hotels on the hill above the town, for he never saw her except on the beach in the mornings, where she was much admired for her swimming, her elegant figure and her very original bathing costumes.

His other lady friend, also charming, and also, but in quite another way, good looking, was staying at the Doctor's Cave Hotel, and gradually she and Mr. Harrison had got into the habit of meeting an hour before dinner, to sit and chat while they drank their rum-punch.

On the previous evening, while they were sitting

together as usual and talking, Mr. Harrison happened to say how surprised he was that she never bathed.

The bathing at Montego Bay, he pointed out, was famous, not only in Jamaica, but the world over; and he tried to persuade her to come and bathe with him one morning. In answer to this the lady, after looking hard at him for a few moments, protested in an injured voice, "But I *do* bathe, every day. I bathed with you this very morning and sat with you for more than an hour afterwards, on the beach!"

"So you see," concluded Mr. Harrison, "there is nothing else for me except to leave, but" he added, turning to my wife, "why, and how do women manage to look so utterly different in evening dress and bathing suits?"

P. G.

## OUR LIBRARY.

(Continued from p. 67.)

In a brief sketch of the history of the Library some reference was made to the history of the Hospital. In giving a short description of the contents of the Library, it is not altogether out of place at this point to refer to other books in the Library dealing with the history of the Hospital.

First and foremost must be mentioned the erudite history of the Hospital by Sir Norman Moore in two impressive volumes. A smaller history by Sir D'Arcy Power makes an admirable introduction to the larger volumes. This was written in 1923 in time for the Octo-centenary celebrations, and a copy on hand-made paper was presented to each of the delegates attending. It also contains prospective plans for the rebuilding of the Hospital by Sir Holburt Waring.

The *Records of St. Bartholomew's Priory*, in two volumes, by E. A. Webb, is also invaluable to the student of the history of the Hospital, because necessarily the two institutions have much in common.

Mr. Marrant Baker, who was Warden of the College from 1867 to 1874, and later became Surgeon to the Hospital, took great interest in its history. In 1885 he published *The Two Foundations of St. Bartholomew's Hospital*, and a reprint of the *Orders and Ordinances for the better government of the hospitall of Bartholomew the lesse*. The latter were originally printed in 1552, and a copy of this edition, published by the Early English Text Society for F. J. and P. Furnivall in 1888 is also in the Library. This volume also contains copies of the 1548 edition (as re-issued in 1577) of Vicary's

*Anatomie of the Bodie of Man*, as well as documents of great interest to the historian.

Marrant Baker also collected prints of our Hospital and kindred institutions, and on his death these were presented to the Library and form the basis of our collection, which was considerably added to by the collection of the late W. H. H. Jessop. The collection has now been classified and catalogued.

An interesting book in the Library is the *Carmen Elegiacum* by Robert Bridges, the late Poet Laureate. The elegiacs are in Latin and start with the foundation of the Hospital. Short impressions of those connected with the Hospital up till the time of publication in 1876 form the chief feature. Dr. Mervyn Gordon, who presented a copy to the Library, says in an inset, "Copies of this are exceedingly rare, as the author is said to have destroyed all of them that he had in his possession". Whether Dr. Bridges was satisfied with his effort or not, the book was reprinted with considerable alterations the following year, but with no indication on the title-page that it was either a reprint or a second edition.

A further reference to Dr. Bridges may be allowed here. In vol. xiv of the *St. Bartholomew's Hospital Reports* he wrote "An Account of the Casualty Department", and a most interesting account it is, although it is whispered it did not meet with universal approval.

A. H. COUGHTREY.

(To be continued.)

## COLLEGE APPEAL FUND.

### SUBSCRIPTIONS TO DATE.

	£	s.	d.	*
Staff . . . . .	12,727	15	10	(72)
Demonstrators . . . . .	1,721	11	0	(69)
Students . . . . .	810	18	3	(290)
Old Bart.'s men:				†
‡Bedfordshire . . . . .	25	3	6	(7) . (26)
Berkshire . . . . .	123	3	0	(16) . (37)
‡Buckinghamshire . . . . .	76	19	0	(14) . (29)
‡Cambridgeshire . . . . .	183	6	0	(17) . (42)
‡Cheshire . . . . .	6	16	6	(3) . (26)
‡Cornwall . . . . .	31	11	0	(8) . (36)
Cumberland . . . . .	5	0	0	(1) . (6)
Derbyshire . . . . .	19	14	0	(4) . (17)
‡Devonshire . . . . .	560	17	0	(52) . (118)
‡Dorset . . . . .	52	1	0	(14) . (30)
‡Durham . . . . .	17	7	0	(4) . (11)
Essex . . . . .	249	19	6	(19) . (69)
‡Gloucestershire . . . . .	229	19	6	(23) . (66)
Hampshire . . . . .	448	16	0	(47) . (134)
‡Herefordshire . . . . .	17	12	0	(4) . (10)
Hertfordshire . . . . .	84	11	0	(16) . (73)
Huntingdonshire . . . . .				(1)
Isle of Wight . . . . .	186	13	0	(13) . (25)
‡Kent . . . . .	578	18	0	(70) . (146)
‡Lancashire . . . . .	91	4	6	(12) . (82)
Carried forward . . . . .	£18,249	16	7	

	£	s.	d.	
Brought forward	18,249	16	7	
Leicestershire	136	15	0	(7) . (28)
†Lincolnshire	58	17	0	(17) . (27)
Middlesex	385	6	0	(21) . (68)
†Norfolk	173	0	6	(21) . (60)
†Northamptonshire	59	4	0	(5) . (17)
†Northumberland	101	1	0	(2) . (11)
†Nottinghamshire	19	19	0	(3) . (28)
†Oxfordshire	190	3	0	(19) . (29)
Rutland				(2)
Shropshire	35	9	0	(8) . (22)
†Somersetshire	1,180	3	0	(28) . (43)
Staffordshire	193	17	0	(5) . (37)
†Suffolk	324	4	0	(25) . (46)
Surrey	473	3	6	(55) . (180)
Sussex	410	1	6	(59) . (174)
Warwickshire	184	7	6	(20) . (56)
Westmorland	2	10	0	(1) . (5)
†Wiltshire	110	11	0	(12) . (26)
†Worcestershire	158	19	6	(24) . (24)
†Yorkshire	302	6	6	(24) . (101)
Wales	61	9	0	(16) . (150)
London	2,920	15	8	(194) . (971)
Channel Islands	20	0	0	(2) . (9)
Scotland	15	5	0	(5)
Abroad	114	1	0	(13)
South Africa	362	15	6	(19)
Canada	114	3	6	(8)
East Africa	87	12	0	(10)
West Africa	146	10	0	(5)
India	201	0	0	(11)
Ireland	19	14	0	(4)
North Africa	1	0	0	(1)
North Borneo	5	5	0	(1)
Australia	122	2	0	(6)
China	52	8	4	(9)
Siam	10	0	0	(1)
France	50	0	0	(1)
British West Indies	50	8	0	(5)
Straits Settlements	7	1	0	(3)
New Zealand	6	1	0	(3)
Services	631	17	6	(44)
Others	32,785	3	5	(342)
Lord Mayor's Appeal	17,933	1	0	
Funds of College	8,000	0	0	
Value of Building	20,000	0	0	

**£106,467 7 6**

\* Number of Bart.'s men subscribing. † Number of Bart.'s men in County. ‡ Counties with Secretaries.

## STUDENTS' UNION.

### ASSOCIATION FOOTBALL CLUB.

#### HALF-SEASON REPORT.

Owing to lack of space the JOURNAL has not been able to publish reports on matches. In view of this a *résumé* of the season to date is appended.

The term's football has been one of splendid success. Not for very many years has the Club had such a run of victories. The season opened with a win 5—2 against St. Thomas's, our opponents in the Cup Final last season. In the following match the Casuals paid us the compliment of fielding a very strong XI, and we were well beaten 0—3. The game against Reading University was a really excellent game of football, and resulted in a draw 1—1. A new fixture against Metropolitan Police College resulted in our losing 2—3, after being 2 up 15 minutes from time. The magnificent physique of our opponents undoubtedly had a lot to do with their victory. From then on seven victories have followed one another. Downing College, Cambridge, was defeated 1—0 in a gale of wind ;

Balliol College, Oxford, lost to us 6—3 ; 6 goals were scored against Old Brentwood's to their 4, Lancing Old Boys were beaten 5—3, and Borough Polytechnic 8—0. On each of these last four matches every forward scored. Old Monovians were beaten 5—1, while finally a Merton XI were trounced 8—0.

For eight weeks, from the Reading game to the game against Merton, the team has been unchanged, and the Committee feel that the policy of sticking to one team has been justified.

The team has been : T. O. McKane (*goal*) ; H. Knowles, G. Herbert (*backs*) ; W. A. Owen, D. R. S. Howell, G. H. Darke (*half-backs*) ; C. Nicholson, P. A. K. Brownlees, N. H. Bloom, C. J. Carey and R. C. Dolly (*forwards*).

The 47 goals scored in the 11 matches have been fairly evenly distributed among the forwards. Nicholson, whose shooting and centring has been outstanding, claims 11, Dolly on the other wing 9, Carey 8, Brownlees 8, and Bloom 7.

The strength or weakness of a team lies in the half-backs, and the Hospital is fortunate in having a wealth of talent.

The 2nd XI have shown a great improvement on last season's record. They have played 12 matches, won 9, drawn 1, and lost 2, scoring 53 goals against 20. Here again success has been largely due to the halves, Maidlow and Waring, who were 1st XI regulars last year. Among the Freshmen, Harold, James and McElder are showing excellent promise.

For the future a stiff programme lies ahead. The two cups have to be defended, and on present form ought to be retained. The 2nd round on Wednesday, February 20th, is a difficult one, being against U.C.H.—always a hard team to beat. A cheer will always help ; so don't forget the date.

If there are any Freshmen coming up this term who play Soccer will they make themselves known to the Secretary ?

## REVIEWS.

ST. BARTHOLOMEW'S HOSPITAL REPORTS. Vol. LXVII. (London : John Murray, 1934.) Pp. xxiv + 279. Price 15s.

This volume is well worth possessing, if only for the group of papers on goitre. That by Dr. A. W. Spence dealing with his researches on the aetiology of goitre should be read first, and together with the three lectures by Prof. Fraser on the treatment of toxic goitre, and the one by Sir Thomas Dunhill on the surgery of the condition, provide the reader with a clear conception of modern views on its causation and management. The Editorial Committee is to be congratulated on obtaining this comprehensive review of the joint work of the Professorial Units on goitre before Prof. Fraser's departure.

There is a symposium on the problem of peptic ulcer, which is concerned chiefly with the results of the treatment of simple ulceration of the stomach and duodenum as judged by the reports from the Follow-up Department. Prof. H. H. Woollard and Prof. E. H. Kettle contribute valuable summaries of the anatomical and pathological considerations bearing upon the nature of the process of ulceration as a guide to treatment, and Dr. Geoffrey Bourne has written a short account of his experience of duodenal feeding which should prove a great help in practice. Mr. R. W. Raven has produced a most illuminating analysis of 357 cases of chronic gastric ulcer, and 272 cases of chronic duodenal ulcer which have been followed up since 1929, and his main object has been to try to deduce the features which should lead us to advise prolonged medical treatment or to have recourse to surgery as an adjuvant to medical methods. Mr. Girling Ball has made an independent review of 58 of his own cases of gastric ulcer treated by partial gastrectomy, and brings forward good evidence to show that this operation ensures the best after-results in cases of chronic ulcer in the common situation on the lesser curvature which have not yielded to medical treatment.

In addition to these two groups of papers there is an instructive article by Dr. A. Q. Wells pointing out the importance of  $\beta$ -hydroxybutyric acid as the active agent in the treatment of urinary infections by ketogenic diet, and two papers by Dr. I. J. Wood and Dr. A. W. Franklin on the detailed investigation and treatment of some unusually interesting cases of anaemia in infancy. Mr. William Foster Cross, Consulting Anaesthetist to the Hospital, died in July,



1934, and Mr. West has written a sympathetic appreciation of an admirable character who will long be remembered by large numbers of old Bart.'s men. Brief accounts of the activities of the Library, Museum and the Hospital societies complete a volume which is intended primarily to keep Bart.'s men in touch with the life of the Hospital and Medical College.

**A MANUAL OF PRACTICAL ANATOMY. Part I: Upper and Lower Limbs.** By THOMAS WALMSLEY. (Longmans, Green & Co.) Pp. viii + 376. Price 12s. 6d. net.

Although this manual was first published immediately after the war, one feels that it has only recently made itself known to students in the London medical schools. In most of these the student relies on one of two well-known dissecting manuals to guide him in his practical work. He wisely refrains from experimenting with less well-known text-books. Indeed any new anatomical text-book must be regarded with suspicion unless it has some distinct claim to originality, for there is already a sufficiency of the larger works, and a definite excess of those volumes which are recommended for their small size, and whose value is as small as their size.

But Prof. Walmsley's book departs from the traditional arrangement of a dissector's guide. In the first part—with which this review is concerned—the anatomy of the arm and leg is considered. The first fifty pages are devoted to a description of the various structural elements of a limb. Many interesting facts are clearly stated, the description of muscular form and the mechanics of muscular contraction being particularly good. In the remainder of the book the anatomy of the limbs is considered originally, and interspersed with the ordinary descriptions there is a minimum of instructions to the dissector. The latter fact makes the book more readable to those not actually using it during dissection. There is a large number of very clear diagrammatic drawings of dissected specimens which the student is invited to colour. A number of diagrammatic cross-sections of both limbs is a useful feature. These have not been annotated, so that in doing so the student will have impressed upon his mind the details of the various sections—knowledge which is useful not only in the examination room, but also in the surgery of amputations.

Throughout the book an endeavour has been made to stress important practical points, such as the anatomy of the breast, the mechanical functions of the clavicle, the tarsal joints and their movements, etc. A complete account of the regional anatomy of the limbs is given, no important fact is omitted, the style is clear and the book easy to read. It can be confidently recommended, especially for revision before examinations, and can be read with greater ease and much more benefit than the very popular books "which can be easily slipped into the pocket"—and which for the most part are best left there.

**SURGICAL APPLIED ANATOMY.** By Sir FREDERICK TREVES. 9th edition. Revised by Prof. G. C. CHOYCE. (Cassell & Co.) Pp. 720. Price 14s. net.

Treves' *Surgical Anatomy* is a classic which has been altered and improved with the advance of surgical knowledge. It gives a clear account of the essential anatomical details of the various regions of the body, with an outline of their practical applications. While there are other text-books of applied anatomy which are of greater value as works of reference, and give far better accounts, for example, of the sympathetic nervous system, yet, for general purposes and preparation for all surgical examinations, this book must still hold the first place. The book is well produced, and the majority of the illustrations are satisfactory. It seems a pity that the annotations in Fig. 88 should be in the B.N.A. terms, which in this instance are barely understandable, and not in accord with the text or previous illustrations.

**GONOCOCCAL INFECTION.** By R. V. STORER, M.R.C.S., L.R.C.P. (John Bale, Sons & Danielsson.) Pp. viii + 91. Price 7s. 6d.

This book has a two-fold object—primarily to assist in the field of research, and to guide the general practitioner in his treatment of a case of gonorrhoea.

Apart from the accuracy of many statements in the first two parts being open to criticism from a technical point of view, the first question which arises is, "What purpose do they fulfil in the diagnosis and treatment of a case of gonorrhoea by the general practitioner?" The majority of these parts consists of a mass of detailed pathology difficult to understand and at times even to accept; it would seem that these can do little to help in the diagnosis of gonorrhoea.

The section on treatment begins with an interesting *résumé* of methods of treatment; they are dismissed rather summarily, some justifiably, others without justification. Surely oral urinary antiseptics do not predispose to complications; they may do little good, but they do no harm, while their psychological effect is frequently valuable. The section continues with a method of treatment advocated by the writer which is in many ways orthodox, but on certain points unusual. Undue space is given to vaccine preparation of little interest or value to the practitioner.

After reading the book a general practitioner must feel that treatment is difficult, and that he needs a wide selection of chemicals and a complex armamentarium of instruments for the treatment of those infrequent cases of gonorrhoea occurring in his practice which may be able to remunerate him adequately for his skill, time and overhead expenses.

The book is interesting to read, but one hardly feels that it has achieved the object of clarifying the field of research in the subject.

**VENEREAL DISEASE: ITS PREVENTION, SYMPTOMS AND TREATMENT.** By WANSEY BAYLY. 5th edition. (London: Chapman & Hall, Ltd.)

Having reached the fifth edition in the space of fifteen years, this book has proved its usefulness to the profession. The value of this work lies in the fact that here we have the essentials for the prevention, diagnosis and treatment of venereal disease in a concise and readable form. This edition is entirely up to date and embraces recent advances in the treatment of general paralysis and tabes. A useful bibliography is given for those who wish to pursue the subject further.

The book is recommended to practitioner and student as a concise work on the subject of venereal disease.

**THE CANCER PROBLEM AND ITS SOLUTION.** By HASTINGS GILFORD. (London: H. K. Lewis & Co., Ltd.) Pp. ii + 60. Price 2s. 6d.

The author believes that there is no disease about which we have accumulated more facts than cancer, and that no more facts are needed in order to determine the genesis of the disease. This statement is, of course, open to criticism. He discards much of that which has come to light from animal experimentation, and believes that the problem has been obscured by these experiments rather than clarified. We agree with the attitude that a good deal more attention should be given to the study of cancer in man.

The idea is put forward that the precancerous state is due to the appearance of embryonic characteristics in the cells before their time. These cells are vulnerable to certain stimuli which cause multiplication, and eventually a new parasitic growth which we call cancer. The nature of these stimuli are discussed, together with those factors which favour the occurrence of precancerous cells.

The book is interesting, and will be profitable reading for those who are engaged in elucidating the cause of cancer.

The Editor regrets that it has been found necessary to postpone the concluding chapters of "The Life and Works of Charles Barrett Lockwood, 1856-1914", by Mr. E. C. O. Jewesbury.

## RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

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- ADAMSON, H. G., M.D., F.R.C.P. "Eczema as a Clinical Entity and its Fundamental or Essential Lesion." *British Journal of Dermatology and Syphilis*, December, 1934.
- AINSWORTH-DAVIS, J. C., M.D., F.R.C.S. "Chronic Cervicitis: Its Influence on the Urinary Tract and its Treatment by the Diathermy Caustic." *British Medical Journal*, November 24th, 1934.
- ANDREWES, C. H., M.D., M.R.C.P. "Viruses in Relation to the Aetiology of Tumours." *Lancet*, July 14th and 21st, 1934.
- (and LAIDLAW, P. P., F.R.C.P., F.R.S., and SMITH, W., M.D.). "Susceptibility of Mice to the Viruses of Human and Swine Influenza." *Lancet*, October 20th, 1934.
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- BURN, G. WILSON, M.R.C.S.E. *Stories and Recollections*. Holt, Rounce & Wordey, 1934.
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- "Thoracoscopy by Single Puncture." *Lancet*, August 18th, 1934.
- FINZI, N. S., M.B., and MAXWELL, JAMES, M.D., M.R.C.P. "Irradiation Treatment of Malignant Intrathoracic Tumours." *British Medical Journal*, October 20th, 1934.
- CHOPRA, R. N., M.A., M.D., I.M.S. (and MUKHERJEE, S. N., and SUNDAR RAO, S.). "Studies on the Protein Fractions of Blood Sera. Part I, Normal and Filarial Blood Sera." *Indian Journal of Medical Research*, July, 1934.
- (and GHOSH, N. N., and MUKERJI, A. K.). "Anthelmintic Properties of *Vernonia anthelmintica* Willd. (Syn. *Serratula anthelmintica*)." *Indian Journal of Medical Research*, July, 1934.
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## EXAMINATIONS, ETC.

## University of London.

## Third (M.B., B.S.) Examination for Medical Degrees, November, 1934.

*Pass.*—Blomfield, D. M., Capper, W. M., Cartwright, W. H., Jones, F. Avery, Kingdon, J. R., Purnell, R. H., Reavell, D. C., Roden, A. T., Russell, B. F. B., Smith, M. C. L., Stephens, K. F., Tregaskis, T. G.

## Supplementary Pass List.

*Group I.*—Harvey, P. G. F., Kanaar, A. C.

*Group II.*—Jones, D. M., Martin, J. R. M.

## CHANGES OF ADDRESS.

ABERCROMBIE, G. F., 76, Fitzjohn's Avenue, Hampstead, N. W. 3. (Tel. Hampstead 0652.)

CARVER, A. E. A., Cassel Hospital for Functional Nervous Disorders, Swaylands, Penshurst, Kent.

CLARK, FRANCIS, 41, King's Road, Berkhamsted, Herts. (Tel. Berkhamsted 657.)

HANKEY, GEORGE T., 100, Harley Street, W. 1. (Tel. Welbeck 6343.)

MATHESON, I. W., King Edward VII Hospital, Windsor, Berks.

MAXWELL, J. P., Union Medical College, Peiping, N. China.

THWAITES, P., "Chalk Hills", 52, Beverley Road, Whyteleafe.

WAY, L., 108, Plashet Grove, East Ham, E. 6.

## APPOINTMENT.

CARVER, A. E. A., M.D., D.P.M.(Cantab.), appointed Medical Director of the Cassel Hospital for Functional Nervous Disorders, Swaylands, Penshurst, Kent.

## BIRTHS.

BAXTER.—On November 30th, 1934, at a West End nursing home, to Betty, wife of Dr. William Baxter, 61, Whitton Gardens, Greenford, Middlesex—a daughter.

BOLTON.—On October 14th, 1934, at the Methodist General Hospital, Hankow, to Eileen, wife of Dr. Ralph Bolton—a son.

DOYLE.—On November 7th, 1934, at The Square, Fakenham, Norfolk, to Gladys (*née* Martin), wife of Dr. J. L. C. Doyle—a son (Christopher John).

GORDON.—On November 28th, 1934, at 20, Devonshire Place, W., to Phyllis (*née* Milholland), wife of Dr. E. F. S. Gordon—a son.

MCCURRICH.—On November 25th, 1934, at 31, Brunswick Road, Hove, to Bettine, wife of H. J. McCurrich, M.S., F.R.C.S.—a daughter.

POPE.—On December 1st, 1934, at Buckingham, to Barbara (*née* Innes-Lillingston), wife of Dr. E. S. Pope—a daughter.

RUSSELL.—On December 4th, 1934, at Mohnyin, Upper Burma, to Muriel (*née* Selwyn), wife of S. Farrant Russell, F.R.C.S.—a daughter.

WILLIAMSON.—On December 15th, 1934, to Muriel, wife of Dr. H. W. Williamson, of 33, Westbourne Terrace, W. 2—a son, who survived only a few hours.

WILLIS.—On November 29th, 1934, at Sussex House Sutherland Avenue, W. 2, to Rosalie, wife of Dr. Saxby Willis—a daughter.

## MARRIAGES.

APTHORPE-WEBB—MASTIN.—On November 21st, 1934, in London, Dr. Hugh Apthorpe-Webb to Kathleen Mastin.

HARVEY-WILLIAMS—MARSHALL.—On December 6th, 1934, at St. Andrew's, Cheam, Robert Harvey-Williams, F.R.C.S., to Evelyn Margaret (*née* Orr-Ewing), widow of Lieutenant Herbert Marshall, R.A.F.

MELLOWS—WEBB.—On November 27th, 1934, at the Guildhall, City of London, Dr. Percival B. P. Mellows to Gwendolen Webb.

WILLIAMS—SIZER.—On December 22nd, 1934, at Northaw Church, Hertfordshire, T. P. Williams to Evelyn Sizer, of Adrogué, Buenos Ayres.

## DEATHS.

BIRD.—On December 6th, 1934, at 43, Church Road, Whitechurch, Glamorgan, after a short illness, Dr. Ashley Bird, aged 78.

ELLIS.—On December 19th, 1934, at Victoria, British Columbia, Henry Reginald Ellis, M.B., Barrister-at-Law, sometime Assistant Director of Medical Services, Nigeria, aged 61.

FOUNTAIN.—On November 25th, 1934, at Crossley House, Ruislip, Edward Osborne Fountain, B.A., M.D., aged 77.

MOORSHEAD.—On December 4th, 1934, at his home at Fairfield, Cornwall Road, Sutton, Surrey, Robert Fletcher Moorshead, M.B., F.R.C.S., aged 60.

## NOTICE.

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